BEFORE THE MINNESOTA

EMERGENCY MEDICAL SERVICES REGULATORY BOARD

In the Matter of
Thomas Mach, EMT-P
Certificate Number: 224810

FINDINGS OF FACT, CONCLUSIONS, AND FINAL ORDER

On February 23, 2004, the Complaint Review Panel ("Panel") of the Minnesota Board of Emergency Medical Services ("Board") initiated the above-entitled proceeding against Thomas Mach, EMT-P ("Respondent"), by service of Notice of Petition and Petition to Suspend Certification.

The matter came on for consideration by the Board pursuant to Minnesota Statutes section 144E.28, subdivision 5(b) (2002), at a regularly scheduled meeting on March 25, 2004, convened in Conference Room A (fourth floor), University Park Plaza, 2829 University Avenue S.E., Minneapolis, Minnesota 55414.

Rosellen Condon, Assistant Attorney General, appeared and presented oral argument on behalf of the Panel. Respondent was not present or otherwise represented at the meeting. Nathan W. Hart, Assistant Attorney General, was present as legal advisor to the Board.

The following members of the Board were present: James Aagenes; Dean Albers; Bonnie Bleskachek; Roger Boatman; Brenda Brown; Robert Carlson; Robert Dahm; Kary Kaye; Mark Lindquist, M.D.; Donald Otte; Michael Parrish; Mary Sheehan; and Linda Way. As members of the Panel, Megan Hartigan and Brian LaCroix did not participate in deliberations or vote in the matter.

Based on the record and the proceedings herein, the Board makes the following:

FINDINGS OF FACT

1. On February 22, 2003, while employed by Hennepin County Medical Center ("HCMC") Emergency Medical Services and functioning as a paramedic, an emergency call was taken by Respondent. Respondent recorded a Methodist Hospital arrival of 10:27 hours, not clearing the hospital until 10:59 hours. Another ambulance was at the hospital from 10:50 to 11:06 hours, and its crew did not see Respondent in the Emergency Department. As this ambulance left the hospital, its crew saw Respondent's vehicle in the back parking lot. According to the hospital records, the patient transported in Respondent's vehicle was admitted to the Emergency Department at 10:10 hours on February 22, 2003. Respondent documented in the patient care report his arrival time of 10:27 hours, 17 minutes after the Emergency Department recorded the patient admission. Seventeen minutes was not accounted for, indicating Respondent manipulated and falsified his hospital arrival time.

2. An examination of the patient care report for this run also revealed Respondent recorded the reason for the call as "medic." However, the call was conveyed to Respondent by the Communications Center as "stroke." The patient care record established Respondent's partner as attending, and Respondent suggested the patient's symptoms were related to the patient's sleeping position rather than suspecting a neurological cause. However, the Emergency Medicine physician recorded the admitting diagnosis as CVA. A blood sugar test was administered, but Respondent failed to provide any other treatment, including oxygen.

3. A further review of patient care reports by EMS supervisors for February 22, 23, and 25, 2003, disclosed that nearly all of the emergency calls on these days were out of compliance. Moreover, all of the emergency calls to which Respondent responded exceeded the

conservative travel times provided by internet maps and tested by EMS supervisors Code 2, indicating Respondent delayed his response and failed to respond Code 3, when required.

4. In addition, the review of patient records revealed that the "Reason for Call" field on the patient care reports consistently had "medic" recorded rather than the reason provided by the HCMC Communications Center.

5. Further examination revealed that Respondent delayed in leaving the hospital on February 22, 2003, which placed him in a better position to procure a more favorable station assignment and allowed him to avoid responding to a personal injury accident only a short distance from the hospital at Meadowbrook and Excelsior Boulevard, to which another HCMC ambulance was sent.

6. On March 19, 2003, based on the previous concerns, surveillance was conducted of Respondent and his partner. On that date, Respondent was on the air, in the intersection at Diamond Lake and Nicollet Avenue South, and proceeded to the Holiday gas station. Respondent gave his location as 66th Street and Nicollet. Respondent stopped to use the restroom and purchased milk before responding to the emergency, without authorization. Respondent advised EMS Communications that he was en route; however, he did not actually respond. Respondent gave a false location and delayed an emergency response by four minutes. Another paramedic crew cleared a scene and was reassigned to Respondent's call.

7. On that same date, Respondent was sent from MFD Station 27 to 5757 Irving Avenue South, on a "heart" call at a school. Respondent failed to respond Code 3, with lights and sirens, as specifically instructed by HCMC Communications, delaying the emergency response.

8. Following the call at 5757 Irving Avenue South, Respondent left the scene at 11:32 hours. Respondent failed to transport a patient, nor did he advise the HCMC EMS Communications Center of the change in status or availability. Following a brief roadside stop, Respondent moved to 60th Street and Russell Avenue South. The EMS Communications Center believed he was still at 5757 Irving Avenue South evaluating a patient. The Communications Center was not aware of the personal stop, nor was the stop authorized. It was not until 11:59 hours that Respondent notified the Communications Center he was available and had left the patient, approximately 27 minutes earlier. Respondent did not leave his position at 60th Street and Russell Avenue South, and at 12:15 hours, the Communications Center asked for Respondent's location. Respondent stated, "62 and Penn," a false location.

9. At 12:20 hours, Respondent was confronted by EMS supervisors for making an unauthorized stop at his grandfather's residence, not moving to the post assignment.

10. During the three-hour surveillance period, Respondent committed the following offenses:

a. Failed to advise the EMS Communications Center of his availability or change in location;

b. Falsified the patient care record;

c. Performed an unauthorized stop, making himself unavailable for 27 minutes;

d. Advised EMS Communications of his status change only after another paramedic crew became bravo in order for Respondent to receive a preferential station assignment;

e. Deceived the Communications Center by falsifying his location when asked for verification; and

f. Failed to position himself for coverage as directed, compromising coverage for another 21 minutes.

11. On March 27, 2003, Respondent's employment was suspended with pay with the intent to dismiss on April 3, 2003. On April 3, 2003, Respondent submitted his resignation.

12. Respondent failed to cooperate with a Board investigation by failing to respond to a letter sent to him on behalf of the Board on or about April 18, 2003, asking him to submit a written response to the foregoing allegations.

13. A Notice of Conference ("Notice") was served on Respondent on October 7, 2003. It established the October 27, 2003, conference date and requested that Respondent submit a written response to the allegations set forth in the Notice prior to the conference. In addition, the Notice informed Respondent that his failure to attend the conference could constitute independent grounds for Board disciplinary action against his certification as an EMT-P under Minnesota Statutes section 144.30, subdivision 3.

14. Respondent failed to appear before the Panel on October 27, 2003, however, and again provided no prior notice that he would not be present. Further, Respondent failed to provide any written response to the allegations referenced in the Notice. In conclusion, the Panel determined it would write to Respondent asking him to voluntarily surrender his EMT-P certificate due to his discharge from HPSP and his failure to cooperate with the Board. Alternatively, Respondent would be provided a final opportunity to meet with the Panel on November 18, 2003. If Respondent elected to meet with the Panel, his advance written response

to the Notice allegations would also be required. Board staff mailed Respondent a letter on October 29, 2003, outlining the foregoing options.

15. Respondent did not respond to the Panel's request that he surrender his certificate. Likewise, he failed to appear before the Panel on November 18, 2003, provided no prior notice that he would not be present, and submitted no written response to the Notice allegations.

Based upon the foregoing Findings of Fact, the Board makes the following:

CONCLUSIONS

1. The Board has jurisdiction in this matter pursuant to Minnesota Statutes sections 144E.28 and 144E.30 (2002).

2. Respondent was given timely and proper notice of the February 19, 2004, hearing before the Board and of his right under Minnesota Statutes section 144E.28, subdivision 5(b), to request a contested case hearing to be conducted in accordance with Minnesota Statutes chapter 14.

3. The Panel has complied with all relevant substantive and procedural requirements of statute and rule.

4. The Panel has proven by a preponderance of the evidence that Respondent has violated Minnesota Statutes section 144E.30, subdivision 3, by failing to cooperate with a Board investigation.

5. The Panel has proven by a preponderance of the evidence that, within the meaning of Minnesota Statutes section 144E.28, subdivision 5(5) and (6), Respondent is actually or potentially unable to provide emergency medical services with reasonable skill and safety due to engaging in unethical conduct likely to deceive, defraud, or harm the public or demonstrating

a willful or careless disregard for the health, welfare, or safety of the public and maltreating or abandoning a patient.

6. As a result of the violations set forth above and Respondent's failure to request a contested case hearing within 30 days of receipt of notice of his right to do so or at any time, the Board has the authority without further proceedings to take disciplinary action against Respondent's EMT-P certification. Minn. Stat. § 144E.28, subds. 4 and 5 (2002).

Based on the foregoing Findings of Fact and Conclusions, the Board issues the following:

ORDER

1. Respondent's EMT-P certificate is **SUSPENDED**, effective immediately. At no time subsequent to the date of this Order shall Respondent engage in any act in Minnesota which constitutes practice as an emergency medical technician-paramedic as defined in Minnesota Statutes sections 144E.001 and 144E.28, nor shall he in any manner represent or hold himself out as being authorized to so practice.

2. Not later than 7 (seven) days from the date of this Order, Respondent shall surrender and cause the Board to receive his current EMT-P certificate card.

3. Respondent may apply to the Board for reinstatement of his certification as an EMT-P not earlier than 6 (six) months from the date of this Order. Any such application shall be accompanied by evidence of compliance with all applicable continuing education or training requirements under Minnesota Statutes section 144E.28, subdivisions 7 and 8 (2002).

4. Respondent shall appear before the Panel to review any application for reinstatement submitted pursuant to paragraph 3. The burden of proof shall be on Respondent to demonstrate that he is able to provide emergency medical services in a fit and competent manner without risk of harm to the public. The Board reserves the right to approve an application for

reinstatement only upon the imposition of conditions and limitations which the Board deems necessary to ensure public protection.

5. This Order is a public document.

The foregoing Findings of Fact, Conclusions, and Order constitute the Decision of the Board in this matter.

Dated: May 24, 2004

MINNESOTA EMERGENCY MEDICAL SERVICES REGULATORY BOARD

By: _____
Chair

AG: #981654-v1